Demonstrating the Value of School-Based Health Centers in Maryland: A Roadmap

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for

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Table of Contents

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Executive Summary

The Maryland Community Health Resources Commission and the Council on the Advancement of School-Based Health Centers (Council) partnered with Harbage Consulting to develop a white paper on demonstrating the value of school-based health centers (SBHCs) in Maryland. To complete this paper, Harbage Consulting reviewed publicly available information on SBHCs in Maryland, conducted a series of stakeholder interviews, interviewed national experts and SBHC administrators in other states, and reviewed state and national information.

Findings

Harbage Consulting found that SBHC stakeholders are committed to providing high quality services to children and reducing barriers to care. SBHCs fill a critical role in the health care system by providing needed acute and ongoing physical and mental health services to children in Maryland schools, particularly in underserved areas.

However, the state is not collecting the data it needs to adequately describe the demographics of its enrollees, measure health outcomes, or demonstrate the overall value of SBHCs. This lack of information can be attributed to limited state capacity and resources, inadequate data collection tools, and insufficient collaboration between state agencies and SBHCs, health plans, and primary care providers.

Recommendations

Harbage Consulting recommends that the state and the Council develop a data reporting process with the ultimate goal of having comprehensive state-level information on SBHC enrollees, operations, services, health and education outcomes, and cost savings. We recommend implementing the data reporting process in three phases:

- **Phase 1 – Data Reporting Plan and Performance Measures Collection**
- **Phase 2 – Data Analysis and Dissemination**
- **Phase 3 – Data-Driven Decision-making and Technical Assistance**

It will take time, effort, and collaboration to fully develop and implement this data reporting process. However, the end result of having information about the care provided in SBHCs and using it to drive decision-making and SBHC improvements will be critical to ensuring that SBHCs are maximizing their impact on children's health and education and reducing costs across the state.

We recommend that the state establish a School-Based Health Center Program Office that would be responsible for administering and overseeing all aspects of SBHCs. The state and the Council should identify which entities have the expertise, resources, and the capacity to lead each element of SBHC administration, including the data reporting process. State and Council efforts should continue to improve the value proposition for SBHCs by helping ensure that the data findings accurately reflect SBHCs' contribution to a high-quality system of care for children.

Introduction

The Maryland Community Health Resources Commission (CHRC) and the Council on the Advancement of School-Based Health Centers (Council) partnered with Harbage Consulting to develop a white paper on demonstrating the value of school-based health centers (SBHCs) in Maryland. This includes the role that SBHCs play in improving children's health and educational outcomes, and in achieving cost savings.

To complete this effort, Harbage Consulting reviewed all publicly available information on SBHCs in Maryland and conducted a series of stakeholder interviews. Interviews were conducted with:

- Maryland SBHC Administrators from two counties, one Federally Qualified Health Center (FQHC), health plan staff, SBHC health care providers, Council leadership, Maryland Assembly for School-Based Health Care (MASBHC) board members, and Maryland State Department of Education (MSDE) and Maryland Department of Health (MDH) representatives;
- National School-Based Health Alliance (2 interviews);
- Michigan Department of Health and Human Services; and
- Seattle & King County (Washington State) Health Department.

We also attended two Council meetings. We were unable to interview additional SBHC Administrators or students (and/or their parents) served by SBHCs.

Our team reviewed literature from state and national studies on the impact of SBHCs on health outcomes, education outcomes, and cost savings. Additionally, we researched publicly available information on various websites, including the SBHA, states, and state school-based health alliance chapters regarding state SBHC data, administrative structures, and funding.

Background

SBHCs have long played a critical role in providing a comprehensive array of health care services to children in Maryland schools. SBHCs are "health centers, located in a school or on a school campus, that provide onsite comprehensive preventive and primary care health services. Services may also include mental health, oral health, ancillary, and supportive services."[i] SBHCs are staffed by a range of health care providers, such as pediatricians, family practitioners, nurse practitioners, physician assistants, registered nurses, mental health providers, and/or other provider types.

There are currently 84 SBHCs located in 12 of Maryland's 24 jurisdictions. During the 2017 – 2018 school year, 40,551 students were enrolled in 86 SBHCs. SBHCs provided services to 15,081 of these students over the course of 52,254 visits.[ii] More than two-thirds of the visits were for somatic health care, nearly one-third for behavioral health, and other services including dental care, substance use, and case management.[iii]

Administration and Oversight

The Maryland State Department of Education (MSDE) Division of Student Support, Academic Enrichment, and Educational Policy oversees the administration of $2.6 million in state grant funding to 72 of the 84 SBHCs,[iv]. SBHCs that receive MSDE funding submit application budgets, quarterly financial invoices, and interim and final reports. It is very important to note that the $2.6M does not fund the 72 SBHCs in full; these monies support a portion of the 72 SBHC's overall budget. MSDE also oversees the administration of the SBHC program, which involves reviewing and approving new and ongoing SBHC applications; responding to SBHC questions; conducting site visits; providing technical assistance; and consultation to MSDE School Facilities Branch for architectural plan review of new and existing SBHCs.

The Maryland Department of Health (MDH) provides clinical and subject matter expertise on SBHC applications, attends telehealth site visits and some SBHC site visits when needed (primarily to new sites), approves SBHCs for the purpose of receiving Medicaid reimbursement, provides consultation to MSDE School Facilities Branch for architectural plan review of new and existing SBHCs, and receives health care encounter data for Medicaid enrollees from Medicaid managed care organizations (Medicaid MCOs) and Beacon Health Options (the state's behavioral health administrative services organization).

The Council on Advancement of School-Based Health Centers, herein referred to as the Council, was established by the state legislature in 2015 to "improve the health and educational outcomes of students who receive services from SBHCs by advancing the integration of SBHCs into the health care system and the educational system."[v] The Council's mandate is to facilitate collaboration between state entities and other stakeholders that play a role in administering SBHCs and provide advice and recommendations on improving and advancing the role of SBHCs across the state.

A key partner in the advancement of school-based health care is the Maryland Assembly on School-Based Health Care (MASBHC). The Assembly is a non-profit advocacy organization that promotes school-based health care as a means to advance the belief that all Maryland children and youth have a basic fundamental right to access and receive comprehensive, quality health care. MASBHC is committed to advocacy, facilitating professional learning, providing technical assistance, and ensuring quality school-based health care in Maryland. MASBHC has advanced local, state, and federal legislation to better support school-based health centers. For the past twenty years, MASBHC has been a critical partner to the advancement of school-based health in Maryland.

As specified in COMAR 10.09.76.03, Medical Care Programs: School-Based Health Centers, Conditions for Participation, SBHCs must have a sponsoring agency, which have Memorandums of Understanding (MOUs) with the school system to provide funding, staffing, medical oversight, and/or liability insurance and are responsible for developing and overseeing the SBHC's policies and quality improvement activities. According to Maryland COMAR regulations,

sponsoring agencies can be Local Health Departments, Federally Qualified Health Centers (FQHCs), and General Clinics as defined in 42 CFR §440.90. Local Health Departments are the sponsoring agency for approximately 70 percent of SBHCs, FQHCs represent 24 percent, and General Clinics represent 6 percent.[vi]

All SBHCs must meet state-established minimum requirements and are then designated as Level 1, 2, or 3 based on the variety of service types that are provided and hours of operation.[vii] In 2016 – 2017, nearly two-thirds of SBHCs were designated as Level 1, and the remaining SBHCs were split nearly evenly between Levels 2 and 3.[viii]

Funding

The state annually provides $2,594,803 in funding to 72 of the 84 SBHCs.[ix] MSDE reported that this funding level has largely remained the same over the last ten years, which translates into an effective decrease of funding over time. It is important to note that this $2.6 million in state funding only covers a portion of the costs of the 72 SBHCs. Additional funds for SBHCs are received from Medicaid reimbursement, county government, federal grants, private, commercial plan reimbursement, and in-kind donations. SBHC Leadership are developing mechanisms to bring more clarity to the breakdown of respective funding to describe the overall operating budgets.

Medicaid Reimbursement

SBHCs are required to be approved by MDH to receive Medicaid reimbursement. During the 2017 – 2018 school year, MDH Medicaid reported that 78 out of 86 SBHCs submitted claims for Medicaid reimbursement.[x] According to Maryland Medicaid requirements, only FQHCs, Local Health Department clinics, and general clinics are permitted to receive Medicaid reimbursement as SBHCs. Maryland Medicaid regulations do not allow for hospitals to receive reimbursement as sponsoring agencies of SBHCs[xi] It is important to note that Medicaid reimbursement only covers a small portion of SBHC operating costs.

Maryland regulations require Medicaid reimbursement to SBHCs for specified self-referred services that SBHCs provide to students enrolled in Medicaid and MCHP.[xii] Medicaid reimburses SBHCs when they provide the following services, as specified in COMAR 10.09.76.04 Medical Care Programs, School-Based Health Centers Covered Services:

- Comprehensive well-child care, including immunizations in accordance with the Maryland Healthy Kids Preventive Health Schedule according to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards; follow-up testing and treatment based on EPSDT screenings; preventive and primary health services, including acute and chronic care management (not related to EPSDT screening),[xiii] certain dental services; certain family planning services; and specialty behavioral health services.

Medicaid MCOs do not provide Medicaid reimbursement for mental health and substance use disorder services – these services carved out of the MCO benefit package in Maryland and are billed directly to Beacon Health Options, the contracted behavioral health entity for Maryland Medicaid (and are incorporated into the MDH claims system).

Under Maryland regulations, Medicaid reimbursement for SBHC services is only available for students. However, since FQHCs have contracts with Medicaid MCOs, they can be reimbursed for services provided in SBHCs to other Medicaid-enrolled individuals. In some states, Medicaid reimburses for SBHC services provided to other groups of people, such as teachers, school employees, and other community members. Maryland would need a regulatory change in order for Medicaid to reimburse for SBHC services provided to non-students.

Despite the state funding provided to SBHCs through state General Funds, Medicaid, and commercial health plans, there is limited information publicly available about the quality and quantity of care provided in Maryland SBHCs. The data presented above is primarily from the Council's Annual Report. The Council has identified the need to collect more useful and outcomes-based data on SBHC performance and to share more information with stakeholders to demonstrate the critical role SBHCs play for children and families in Maryland.

Maryland Data Collection and Analysis Findings

Harbage Consulting found that stakeholders that play a role in SBHCs are committed to providing high quality services to children and reducing barriers to care. SBHCs fill a critical role in the health care system by providing needed acute and ongoing physical, mental, and oral health services to children in Maryland schools, particularly in underserved and rural areas. They are a common sense and convenient solution to improving access to care by bringing services to where children are; enabling parents to stay at work; identifying health issues early and connecting them to services; decreasing the amount of class time missed; and keeping children out of the emergency department by managing chronic conditions. On a daily basis, SBHC administrators and providers see the positive impact they have on children's health and lives.

> "SBHCs improve health and education outcomes for students, particularly vulnerable students, by keeping them in the classroom and improving their attendance and participation in school. They increase children's receipt of preventive services and keep children out of the emergency room, thereby saving the health care system money and helping children be more productive and engaged adults." - SBHC Provider

However, the state does not currently have the data it needs to adequately describe the demographics of its enrollees, measure health outcomes, or demonstrate the overall value of SBHCs. This lack of information can be attributed to limited state capacity and resources, inadequate data collection tools, and insufficient collaboration between state agencies and SBHCs, health plans, and primary care providers (PCPs), among other challenges. There has also not been a systematic way for all stakeholders – the Council, SBHCs, health plans, PCPs – to engage on data collection and data sharing issues.

All the stakeholders we interviewed commented that they are interested in developing the infrastructure for collecting, analyzing, and sharing data to show the value of SBHCs, including their impact on children's health outcomes, education outcomes, and the resulting cost savings that can be achieved.

Infrastructure and Capacity

A key theme throughout all the interviews was the lack of state infrastructure, resources, and collaboration for administering SBHCs across the state. Currently, one staff person at MSDE serves as the liaison to the 84 SBHCs, in addition to serving as the liaison to the 24 jurisdictions for school health services (school nursing) and other special projects. This position is overseen and supported by one other staff person who also has other job responsibilities. Currently, one staff person at MDH serves as the clinical director to the 84 SBHCs, in addition to serving many other duties. Both positions are funded with state General Fund dollars that are separate from the state's $2.6 million SBHC grant funding.

Overtime staffing resources for SBHC Agency oversight have been decreasing. There are currently no dedicated staff for SBHC oversight. All the stakeholders commended the work of the two MSDE staff and one MDH staff but noted that this level of staffing is inadequate for handling the required workload.

Similarly, individual SBHCs face staffing challenges. This makes it difficult to find time to collect and report program information to the state, and SBHCs often do not have the staff to support this effort. However, as previously noted, FQHCs have greater infrastructure, capacity, and expertise for collecting and analyzing data since they conduct these activities for other purposes.

Most of the stakeholders identified the need for greater interagency collaboration between MSDE and MDH to improve and advance SBHCs in Maryland. Many stakeholders noted that SBHCs present an underutilized opportunity to improve health outcomes, play a larger role in the health care delivery system for children and other populations, and support Maryland's ongoing population health initiatives. Therefore, greater public health and clinical expertise is needed at the state level to support planning and the administration of SBHCs.

Finally, stakeholders were positive about the Council and believe that it plays an important role in facilitating collaboration among stakeholders and providing recommendations to advance SBHCs in Maryland. Given the limited state capacity to move SBHC planning forward, the Council has sometimes been placed in the role of doing the actual work of the program, but that is not the intended function.

Data Collection and Reporting

This section summarizes the data that is being collected by SBHCs and reported to MSDE, shared between SBHCs and health plans, reported to MDH, and other data collection activities that are underway. SBHCs, Medicaid MCOs, and Beacon Health Options are all collecting information about SBHC clients and submitting information to MSDE and/or MDH through various vehicles and information technology systems. Commercial health plans also collect information about the services their members receive.

SBHCs are required to submit information to MSDE and MDH at their initial application to become an SBHC and provide information annually to MSDE. This includes information on their administrative structure, enrollment, and utilization. MSDE-funded SBHCS also submit financial invoices and reports to receive state grant funding. Other information must be submitted at other frequencies. Table 1 below outlines the SBHC information submission requirements:[xiv]

Table 1. SBHC Submission Requirements
Initial Requirements
• Initial MSDE SBHC Application • MDH SBHC Application for Medicaid Reimbursement • Process Evaluation (prior to SBHC opening) • Outcome Evaluation (within 5 years of SBHC opening)
Annual Requirements
• Continuing SBHC Application • Clinical Quality Improvement Objectives (including follow-up responses from previous year and current year projections) • Interim Report • Annual School-Based Health Center Outcome Report Survey • Final Report
Other Frequency
• Invoices for MSDE-funded SBHCs (quarterly) • Site Visit Self-Evaluation (no frequency requirement) • Needs Assessment (every 3 – 5 years)

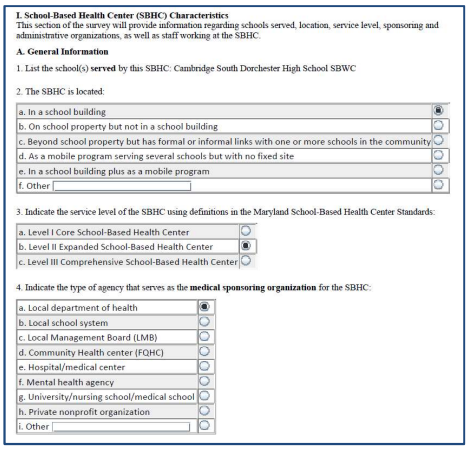
Currently, SBHCs submit a Word version (or sometimes a PDF version) of the new and continuing application by email and mail a hard copy to MSDE. The electronic applications are stored in a folder and paper applications are stored in a filing cabinet. The Annual School-Based Health Center Outcome Report Survey (Annual Survey) is submitted through a web-based tool.

SBHC Annual Survey

Despite the extensive efforts SBHCs are undertaking to collect and submit the required information to MSDE, the state is not currently requesting the data it needs to describe the demographics and insurance status of its enrollees, understand the health outcomes of clients, and demonstrate the value of SBHCs. The Annual Survey – the primary tool used to collect information about SBHCs for the past 12 years – largely focuses on describing the SBHC structure, staffing, and the number and type of services provided. While this is useful information, the Council identified that the Annual Survey questions were not helpful in fully telling the story of SBHCs and made recommendations to MSDE for ways to improve it. The Council, MSDE, and SBHC Administrators have been collectively working to revise the Annual Survey.

SBHCs noted that it is time-consuming and labor intensive to pull the information and produce the reports needed to complete the Annual Survey. One SBHC sponsoring agency we interviewed that has infrastructure and capacity for data analysis noted that their team spends six weeks putting together the required data.

While the latest draft of the Annual Survey is a major improvement over the previous version, our review of the tool found that it still focuses largely on health care utilization and less on the quality of care provided to children and health outcomes. We also found that some of the language in the revised survey needs to be clarified, and that detailed instructions are needed. Otherwise, the state risks collecting non-standardized information across the 84 SBHCs, which can lead to poor data quality and the inability to make conclusions about the performance of SBHCs.



I. School-Based Health Center (SBHC) Characteristics
This section of the survey will provide information regarding schools served, location, service level, sponsoring and administrative organizations, as well as staff working at the SBHC.

A. General Information

1. List the school(s) **served** by this SBHC: Cambridge South Dorchester High School SBWC

2. The SBHC is located:

a. In a school building	◉
b. On school property but not in a school building	○
c. Beyond school property but has formal or informal links with one or more schools in the community	○
d. As a mobile program serving several schools but with no fixed site	○
e. In a school building plus as a mobile program	○
f. Other	○

3. Indicate the service level of the SBHC using definitions in the Maryland School-Based Health Center Standards:

a. Level I Core School-Based Health Center	○
b. Level II Expanded School-Based Health Center	◉
c. Level III Comprehensive School-Based Health Center	○

4. Indicate the type of agency that serves as the **medical sponsoring organization** for the SBHC:

a. Local department of health	◉
b. Local school system	○
c. Local Management Board (LMB)	○
d. Community Health center (FQHC)	○
e. Hospital/medical center	○
f. Mental health agency	○
g. University/nursing school/medical school	○
h. Private nonprofit organization	○
i. Other	○

While we recognize that SBHCs across the country struggle with assessing SBHC costs, the information being collected on the Annual Survey is insufficient for purposes of illustrating the cost of administering SBHCs as well as the total revenue. This makes it impossible to develop even a cursory estimate of SBHCs' return on investment. For example, the revised Annual Survey asks about the category of services SBHCs bill for, the amount billed, and the amount of reimbursement received. While this provides some information about revenue, it does not provide the full revenue picture, nor does it provide insight into the costs of administering an SBHC – including salaries, equipment and other supplies – and how these costs compare to revenue.

It is our understanding that some SBHCs may be collecting additional data beyond what is required by MSDE, but this varies by SBHC and depends on their capacity and the information they are required to submit for other funding sources.

Data Sharing Between SBHCs and Health Plans

Most children who get services from SBHCs are low-income and have public health coverage or are uninsured. Although state-level data is not publicly available on the insurance status of children who receive care in SBHCs (referred to as "clients" in this paper), in one county we interviewed, 73 percent of students who are served in its SBHCs have Medicaid coverage. Most children in Maryland who are enrolled in Medicaid have coverage through a Medicaid MCO.

Maryland's self-referral Medicaid model makes it administratively easier for SBHCs to receive Medicaid reimbursement, since most of them do not meet Medicaid PCP standards (e.g., operating hours). However, this structure has obviated the need for SBHCs to have formal relationships with Medicaid MCOs so very few SBHCs contract with Medicaid MCOs and private health plans. FQHCs are more likely than Local Health Departments and clinics to have formal relationships with health plans due to their connections in other programs.

Data Analysis

Because most SBHCs do not contract with Medicaid MCOs (or private health plans), SBHCs only have information about the services they provide – they do not have information on the services children receive from other health care providers. This limits the SBHC's and state's ability to collect comprehensive utilization data and performance measurement information.

Stakeholders shared that there are a couple of health plans that are particularly proactive in working with SBHCs (i.e., FQHCs) when they have a contract in place on providing information panel management and population health information, but staff turnover at the health plans can hinder this progress. It was also noted that some health plans have pushed back on sharing data due to Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerns when they do not have contracts with the SBHCs.

Care Coordination

With respect to sharing information at the client level, once an SBHC submits a Medicaid reimbursement claim to a health plan, the SBHC and the health plan can share information about that child. Maryland regulations require SBHCs to fax a health visit report to the child's Medicaid MCO and PCP within three business days of the health visit for inclusion in their medical record. If follow-up care is needed, a health visit report must be faxed within one week to the child's Medicaid MCO and PCP.[xv] SBHCs continually seek to establish improved bi-directional data sharing with MCOs to facilitate effective care coordination.

Based on our interviews, it appears that communication between the SBHCs and health plans occurs to varying degrees. In some cases, the health plans actively review the SBHC's notes and follow up with clients who have received care but appear to have unmet health needs. However, SBHCs and health plans are currently not permitted to share information about children who have returned an SBHC enrollment form but have not received services (referred to as "enrollees" in this paper). Nor are health plans permitted to obtain information from schools/SBHCs on whether their members are enrolled in a school that has an SBHC. Therefore, for the majority of SBHCs that do not have contracts with Medicaid MCOs and private health plans, they cannot encourage SBHCs to outreach to children who need services.

Both SBHCs and health plans expressed frustration about their inability to share information and believe that this is a major barrier to improving care coordination across health care provider settings as well as to demonstrating the value of SBHCs. The SBHCs and the health plans we interviewed expressed strong interest in improving their organizational and data sharing connections.

Medicaid MCO Data Reporting to MDH

SBHCs submit Medicaid claims to Medicaid MCOs (and to Beacon Health Options) to receive reimbursement for covered services provided to SBHC clients. Medicaid MCOs then provide information on claims paid to MDH. The claims include the:

- SBHC National Provider Identifier (NPI);
- Place of Service Code of "03" (block 24B); and
- SBHC Name and Address (block 32).

However, the "03" service code is for *all* services provided in a school setting, including those provided by a school nurse not employed by an SBHC. Analyses would have to be conducted to understand which services are specifically provided by SBHCs. Additionally, according to MDH, SBHCs bill Medicaid for services using the NPI and Medicaid provider number of their sponsoring entity. Some SBHC sites do not have a site-specific NPI or Medicaid provider number, but rather use the same sponsoring agency (Local Health Department or FQHC) number across all their locations. In other counties, each SBHC has a unique identifier. All FQHCs enrolled in Maryland Medicaid are collapsed under one NPI number per organization, which makes it difficult to drill down to the school level based on claims data alone.

Therefore, MDH indicated that that they do not have all the data SBHCs may be interested in and that Medicaid MCOs may be better positioned to provide some of this information. There should be further discussion with the appropriate MDH data staff on what data is collected by MDH and how it could be used to help demonstrate the value of SBHCs.

Other MSDE Data Collection

MSDE is collecting some data that could be useful in analyzing the impact of SBHCs on education outcomes. For example, they have been collecting school-level information on chronic absenteeism, but the definition is being revised this year to align with the federal definition. As of next year, it will be included on every school's MSDE Report Card. There will be associated performance goals and schools will have to report what they are doing if not meeting the goals. MSDE also noted that they think SBHCs are collecting information about whether students are returning to class after they visit the SBHC. Additionally, MSDE will be collecting information about school climate.

Data Analysis, Dissemination, and Technical Assistance

Many stakeholders commented that SBHCs are currently submitting a substantial amount of information to MSDE, which could be more fully utilized to help inform SBHC programming and operations and to demonstrate the value of SBHCs. Some stakeholders reported that they submit information but do not receive any feedback or recommendations based on that information. It also appears that the state is not regularly consolidating or analyzing the information submitted by SBHCs. For example, SBHCs annually undertake a required Clinical

Quality Improvement (CQI) effort, but they do not receive feedback on it, and there is no sharing at the state level about these efforts, lessons learned, or best practices. It appears that MSDE staff are reviewing the information SBHCs submit and asking SBHCs questions as needed, but their lack of staff and capacity makes it impossible to comprehensively review SBHC information and share that information with other SBHCs.

Data Analysis

Data from the Annual Survey is housed at The Hilltop Institute (Hilltop). However, it appears that Hilltop's contract is only to serve as the data repository and does not require them to analyze the data. MSDE has two staff members who have administrative rights to the Hilltop's SBHC data, as well as another data person in a separate branch. However, these staff members have a range of data analysis responsibilities within MSDE. This spring, MSDE is bringing on two students from Stevenson University to support these efforts, and they hope to have an ongoing relationship with the University.

Some SBHCs conduct their own data analyses, but this varies by SBHCs and their capacity to do this is very limited. FQHCs have greater capacity to conduct data analyses and are required to do this to fulfill other program requirements.

Dissemination

All the stakeholders interviewed noted that state-level data on SBHCs is not publicly available. Many noted that the only way to obtain this information is to make a special data request to MSDE by email, which is then run through MSDE's internal approval process. Some stakeholders mentioned that people have asked for reports and they have been told that there is not staff to analyze the data and produce the requested report. However, MSDE said they have not received data requests for state-level information from individual SBHCs. Another stakeholder reported that they were told they would have to pay $10,000 to obtain access to Medicaid data that is housed at Hilltop.

Technical Assistance

Based on feedback received from SBHCs on their technical assistance needs, the state and the Council have been trying to bring in state experts to present at the regular SBHC Administrators meeting (e.g., on Medicaid billing). MSDE reported that it is planning to continue to try to leverage various state agency staff to support SBHCs. MSDE also provides individualized support to SBHCs as needed. However, the state does not have a formal process for identifying trends in technical assistance needs nor for providing technical assistance to SBHCs. There are informal vehicles for SBHCs to share technical assistance needs, including at SBHC Administrator meetings and MASBHC's annual conference.

National School-Based Health Center Literature and Data

Many of the challenges that Maryland faces in demonstrating the value of SBHCs are shared by states and SBHCs around the country. However, the national SBHA and some states are increasingly focused on improving SBHC data collection, analysis, and dissemination to further the evidence base for SBHCs. In 2015, the SBHA began an initiative to collect performance measures from SBHCs to demonstrate their value. Michigan and Oregon are two of the states leading the way on improving data collection and analysis to assess the impact and value of SBHCs. (See Appendix A for summaries of the SBHA, Michigan, and Oregon performance measurement efforts.)

Literature on the Value of SBHCs

As states and the SBHA seek to expand data collection and analysis, research continues to be conducted on the value of SBHCs. Michigan and Oregon are primarily focused on how individual SBHC performance compares to statewide performance, as well as on year-to-year performance improvements. Many of the existing studies on SBHCs have been conducted by academic researchers using complex methodologies. These studies show that SBHCs improve health care utilization, health care outcomes, education outcomes, and cost savings.

Utilization and Health Outcomes

Studies show that SBHCs lead to increased health care utilization[xvi] and primary care,[xvii] including recommended immunizations[xviii] and other preventive services.[xix] SBHCs have been found to reduce emergent care visits[xx] including emergency department use,[xxixxiixxiii] and result in fewer hospitalizations,[xxivxxv] particularly for children with asthma.[xxvixxvii] SBHCs have also been shown to provide benefits to students with asthma, including reductions in symptoms and incidents.[xxviii] Additionally, studies show that SBHCs reduce illegal substance use and alcohol consumption. They also increase contraceptive use among females and increase prenatal care.[xxix]

Michigan found that SBHC clients reported significantly better health outcomes and behaviors after three years than non-SBHC clients. This included greater satisfaction with health, greater self-esteem, less physical discomfort, engaging in more physical activity, eating more healthy foods, greater family involvement, and more active social problem-solving skills.[xxx]

Finally, SBHC health education and promotion activities also benefit other students in the schools even if they are not enrolled in SBHCs.[xxxi] Michigan found that the presence of SBHCs in schools was associated with health benefits for the entire student population, such as less physical and emotional discomfort, higher self-esteem, engaging in fewer individual risk behaviors, fewer threats to achievement, and fewer negative peer influences.[xxxii]

Education Outcomes

Studies show that SBHCs have a positive impact on educational outcomes. In a review of the literature, Knopf et al. (2016) found that SBHCs are associated with substantial educational

benefits including "reductions in rates of school suspension, high school non-completion, and increases in grade point averages and grade promotion."[xxxiii] Research also demonstrates the positive relationship between SBHCs and attendance, drop-out rates, and school tardiness.[xxxiv]

A Michigan study found that 95 percent of students were sent back to class after visiting the SBHC.[xxxv] The Oregon student satisfaction survey found that more than half of SBHC clients reported missing less than one class while accessing care at their SBHC.[xxxvi]

Cost Savings

> "SBHCs are an effective and cost-beneficial setting for health care delivery….With moderate costs, SBHCs have generated considerable savings to society, especially to the Medicaid program." – Ran et al.

Studies have also been conducted to analyze the cost savings of SBHCs for the Medicaid program and for parents. SBHCs have been found to reduce inpatient, non-emergency department transportation, drug, and emergency department Medicaid expenses.[xxxvii] SBHCs also help parents avoid productivity loss and income reductions from taking time off work to take their child to the doctor and to care for them at home.

In a review of the literature on cost savings, Ran et al. (2016)[xxxviii] found:

- The calculated annual benefit of <u>each</u> SBHC to society ranges from **$15,028 to $912,878**; and
- SBHCs lead to a positive net savings to Medicaid, ranging from **$30 to $969 per visit** and **$46 to $1,166 per user**.

This cost savings is largely due to averted emergency department use, ongoing support for children with asthma, and increased contraceptive use among females and therefore decreased teenage pregnancy. The variation in the large ranges presented above is attributed to including different benefit components and assumptions about the number of emergency department visits that were avoided due to the use of SBHCs. Additionally, all the studies reviewed by Ran et al. incorporate annual SBHC operating costs, but only a couple of studies factor in start-up costs.

Another study by the Hispanic Heritage Foundation and MSA Management, LLC on SBHCs in East Baton Rouge, Louisiana found that for every $1 annually invested in SBHCs, there is a return on investment of $3.28 (annual savings of $5.3 million on an annual investment of $1.6 million).[xxxix]

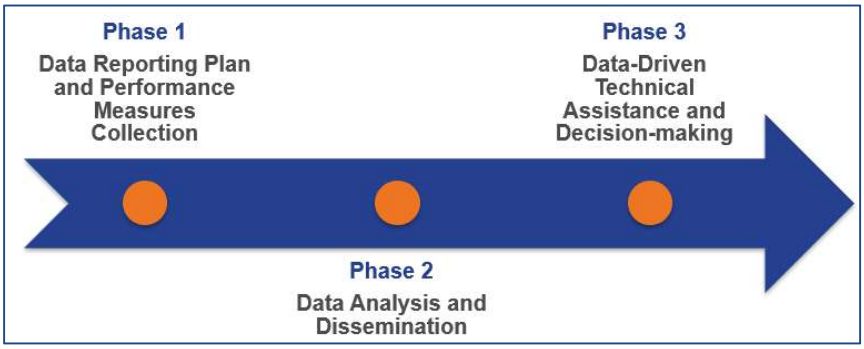
A firm in Michigan is about to release a comprehensive study on the cost savings of SBHCs in the state. Although there is movement toward analyzing the impact of SBHCs, more state data and research is needed to determine the impact on health and education outcomes, and particularly on the cost savings that can be achieved.

Recommendations

Based on Harbage Consulting's findings on SBHCs in Maryland and nationally, this section provides a roadmap of recommendations for developing a data reporting process. The ultimate goal is to have comprehensive state-level information on SBHC operations, services, health and education outcomes, and costs/savings that can be analyzed and used for effective program management, SBHC improvement, and to demonstrate the value of SBHCs in Maryland. This includes information that identifies health care disparities that may exist in order to help move toward health equity. The data reporting process should be guided by the following principles:

- State Investment – The state, including MSDE and MDH, must invest in, prioritize, collaborate in, and lead the development and implementation of, a comprehensive data reporting process;
- Data Sharing – All involved partners must be willing and able to share data, and in accordance with applicable federal and state laws;
- Minimize Burden – Data collection efforts should be streamlined, and technology leveraged, to minimize the burden on SBHCs and partners;
- Transparency – Program information should be analyzed and provided to the full range of stakeholders, recognizing that the level of information needed varies by stakeholder; and
- Actionability – Data should be used to drive improvement and ensure accountability of individual SBHCs, inform state-level SBHC planning and decisions, and demonstrate the value of SBHCs in Maryland.

We recommend developing a comprehensive long-term plan and implementing it in three phases. This will ensure adequate time to create the data reporting process and obtain internal stakeholder buy-in; and to be realistic about the practicality of implementing these changes given the infrastructure, additional resources, and collaboration required. Stakeholders should be prepared for this process to take time to develop and implement.



Phase 1. Data Reporting Plan and Performance Measures Collection

The first phase would involve developing a reporting plan and timeline for establishing the data reporting process through systematic engagement of stakeholders. Achieving stakeholder buy-in on the performance measures and the process for obtaining them will be critical. Below are recommended steps for completing the activities in this phase – these steps should be taken concurrently.

Step 1: Develop Data Reporting Plan, Including Technology Options

The State of Maryland must be willing and able to take on a leadership role in developing a data reporting plan and obtaining buy-in from frontline staff and other stakeholders. The state will also need to dedicate additional resources and staff to strengthening the infrastructure for data collection, reporting, analysis, and dissemination. In the last section of this paper – "Improving the Value of School-Based Health Centers" – we recommend the state create a School-Based Health Center Program Office composed of MSDE and MDH staff with the expertise to oversee all aspects of SBHC administration.

> "Having staff has enabled us to do performance measurement and site reviews – if we didn't have the staff, we wouldn't be able to do all of this."
> – Michigan Dept. of Health & Human Services

The first step is to create a "Data Reporting and Analysis Plan" (Plan) and timeline for developing and implementing a comprehensive data reporting process. This Plan should be developed and monitored by the Council and the Data and Reporting Workgroup, potentially with support from the Commission's part-time contractor or another vendor. A key part of the preliminary meetings should focus on which data outlined in this paper can be shared among partners in accordance with state and federal requirements and whether any immediate contract/MOU additions/revisions are needed. The full Plan should be discussed with all the stakeholders to obtain their input and buy-in, approved by the Council, MSDE, and MDH, and then finalized and distributed.

- *Leverage Technology*

The Plan should include an approach for leveraging existing technology to both store and analyze the data while exploring opportunities to implement a system with additional capabilities. Ideally, SBHCs would be able to leverage their electronic medical record (EMR) systems to pull the required data, and all information that SBHCs submit to the state would be housed in one location. However, it is very important to note that not all Maryland SBHCs have EMRs.

We recommend that the state and Council explore an online database software, Knack,[xl] that is used by Michigan. After years of trying to develop their own database, Michigan decided to

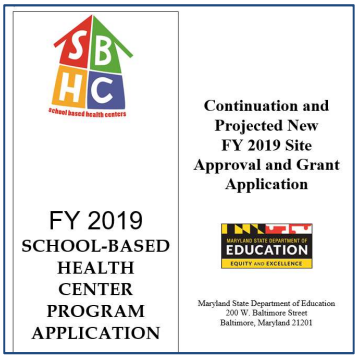
have Knack develop their database, but they can make modifications to it. They reported that Knack is affordable, provides the database structure they need, and produces reports.

Step 2: Determine Performance Measures and Develop Student Satisfaction Survey

- *Collect Additional Performance Measures*

Harbage Consulting recommends adding eight performance measures to the revised Annual Survey. These recommended measures include health and educational outcomes, as well as revenue and costs, and have detailed measure technical specifications that allow for data to be collected and reported in a standardized way. Most of the recommended measures are currently part of, or adapted from, established quality measurement and reporting efforts, including the:

- HEDIS,[xli] from which many of the Centers for Medicare & Medicaid Services (CMS) Child Core Set measures were adapted;
- CMS Child Core Set,[xlii] from which many of the SBHA measures were adapted;
- SBHA, which is encouraging voluntary reporting of five clinical performance measures;[xliii] and
- The California School-Based Health Alliance (CA SBHA).[xliv]



To implement the recommended performance measures, SBHCs, Medicaid MCOs, and private health plans will need to share information and leverage the Chesapeake Regional Information System for our Patients (CRISP) health information exchange. Each of these partners has a piece of information on children's health care utilization and health care quality. In some cases, SBHC partners (Medicaid MCOs, private health plans, MDH) are already reporting on these measures (e.g., to the state and/or CMS). By putting the full picture of information together, the state will be able to show that children who receive SBHC services are receiving needed, appropriate, and comprehensive care.

We recommend starting by assessing the current baseline for each SBHC on the recommended measures and comparing it to the statewide SBHC average. In subsequent years, the state and SBHCs could measure year-to-year improvements. Over time, individual SBHC performance and the Maryland state average could be compared to other states, national benchmarks, and across payers. For example, SBHCs could compare the percentage of children they serve who have had a well-child examination to state and national percentages.

Table 2 below lists the recommended performance measures; sample findings that could be achieved for each measure; and the potential sources of data for each measure. Appendix B includes the definition, rationale, quality measurement reporting efforts each measure aligns with, and links to the measure technical specifications.

Table 2. Recommended Performance Measures		
Measure Name (measure steward)	**Sample Measure Findings**	**Potential Data Sources**
Primary and Preventive Care		
Annual Risk Assessment (SBHA)	X% of MD SBHC clients who had an annual risk assessment, regardless of where the assessment was conducted	SBHCs, Medicaid MCOs, MDH, Private health plans, CRISP
Depression Screening and Follow-Up (SBHA modification of CMS)	X% of MD SBHC clients who were screened for clinical depression and had a follow-up plan, regardless of where the screening was conducted	SBHCs, Medicaid MCOs, MDH, Private health plans, CRISP
Care of Acute and Chronic Conditions		
Asthma Action Plan (N/A)	X% of MD SBHC clients with asthma who have a documented asthma action plan in their health record, regardless of which provider developed it with the client/parent	SBHCs, Medicaid MCOs, Private health plans
Asthma Medication Ratio (NCQA/HEDIS)	X% of children served in SBHCs with persistent asthma had a ratio of controller-to-total asthma medications that signaled their asthma was in control	SBHCs, Medicaid MCOs, MDH, Private health plans, CRISP
Emergency Department Visits (Modification of NCQA/HEDIS)	There were X emergency department visits per 1,000 member months among children in Medicaid/MCHP private health plans who were enrolled in SBHCs There were X emergency department visits per 1,000 member months among children enrolled in Medicaid/MCHP/private health plans in schools with an SBHC compared to Y visits among children in non-SBHC schools	Medicaid MCOs, MDH, CRISP, Privat health plans
Care Coordination		
Timely Transmission of Health Visit Report (N/A)	X% of SBHC clients who needed follow-up care with their PCP had their health visit report transmitted to the PCP within 7 days of the SBHC health visit	SBHCs, Medicaid MCOs, Private health plans

Table 2. Recommended Performance Measures		
Measure Name (measure steward)	**Sample Measure Findings**	**Potential Data Sources**
Education Outcomes		
Classroom Seat Time Saved (SBHA test measure)	X% of MD SBHC client visits resulted in sending students back to class versus their homes, a hospital, emergency room, or external provider	SBHCs
Cost and Budgets		
Operating Income (California SBHA)	MD SBHCs have an average of $X in operating income available after operating expenses are accounted for MD SBHC annual revenue ranged from $X to $Y MD SBHC annual costs ranged from $X to $Y	SBHCs, MSDE

- *Calculate Cost Savings*

  The state could use the data results from some of these measures to develop cursory estimates of cost savings. For example:

  - Emergency Department Visits: MDH could calculate the average cost per emergency department visit for all Medicaid/MCHP enrollees up to age 19; private health plans could also be asked to do this calculation. Using data on emergency department utilization, the state could multiply the difference in the emergency department visit rate for SBHC clients versus non-SBHC clients by the average emergency room cost to identify SBHC-related cost savings.
  - Parent Productivity Time and Income Saved: SBHCs could calculate the difference in the average amount of time to visit an SBHC versus the average amount of time it would take students to seek care from an external health care provider based on data from the Classroom Seat Time Saved performance measure. Multiplying this figure by the number of students seen each year and the median income of parents in the jurisdiction would provide a general estimate of the annual cost savings to the state resulting from the SBHC.

  Later, the state could partner with a local university to develop more thorough analyses of cost savings that incorporate other factors and examine cost savings resulting from specific SBHC services (e.g., asthma care).

- *Develop Client Experience Survey*

  In addition to collecting data on children's access to, and the quality of SBHC services, it is also important to measure clients' experiences receiving those services. Therefore, we recommend that the state implement a client survey. Survey questions could address issues such as communication with providers, the ability to get appointments and needed care, missed class time reduced due to visiting the SBHC instead of going home or to see an external provider, what students would have done if their school did not have an SBHC, and general SBHC satisfaction. To develop the client survey, the Council could leverage surveys that are already being used at some Maryland SBHC sites, as well as those developed by the SBHA, Oregon, and Connecticut.[xlv]

Step 3: Modify, Streamline, and Provide Support on MD SBHC Annual Survey

While we recognize that the revised Annual Survey is still a draft, Harbage Consulting has specific recommendations for opportunities to improve the survey. Appendix C includes detailed suggestions for modifying some data elements to align with technical specifications of measures used in national performance measurement programs. We are also separately providing to the Council suggestions for refining some of the other Annual Survey questions, such as defining each question (as Michigan does)[xlvi] and developing instructions for completing the Annual Survey.

In addition to these detailed suggestions, we recommend streamlining data requests, developing an ongoing process for updating the Annual Survey, and providing technical assistance to SBHCs in completing the Annual Survey.

- *Streamline Data Requests*

  It is important to strike a balance between collecting information and ensuring SBHC accountability while not overwhelming SBHCs with data requests. This balance is particularly important for SBHCs that do not receive state funding. To avoid burdening partners with duplicate reporting requests and reducing the risk of introducing error into the data collection process, every effort should be made to streamline data collection and reporting to the maximum extent possible (e.g., on the application, Annual Survey, site visit self-evaluation, etc.). However, this requires the state to have the capability to analyze all SBHC information – regardless of the data collection vehicle and where the information is housed.

  The Council and MSDE should also review the SBHC Standards and determine whether all the reporting requirements will continue to be needed once the comprehensive data reporting process is in place (e.g., the Outcome/Impact Evaluation). Additionally, the state could also standardize the frequency of site visits so that SBHCs know when to expect them, based on the state's capacity to conduct them.

- *Provide Technical Assistance on Survey*

  To support SBHCs in understanding how to collect, report, and analyze the measures and use the data to improve access to and the quality of care for children, we recommend that Maryland launch a technical assistance program in the year prior to collecting SBHC data on the revised Annual Survey. Technical assistance should be made available through a variety of vehicles, including webinars, one-on-one technical assistance calls, reporting guidance, and in-person data workshops. Additionally, SBHC sponsoring agencies should be encouraged to collaborate on the survey responses when appropriate. Technical assistance should be provided by people who have expertise in the survey data elements, such as state Agency staff and MASBHC, as appropriate. It is important to note that adequate resources are needed to support Agency staff and MASBHC.

  In the first year, technical assistance would primarily be designed to help SBHCs understand the measure technical specifications, including the data elements and/or codes needed to calculate the measures. Since the recommended measures are part of, or adapted from, established quality measurement and reporting efforts, the state can leverage existing technical assistance resources, some of which are specifically developed for SBHCs (e.g., SBHA Technical Measure Specifications, SBHA quality webinars, SBHA tips).[xlvii] In subsequent years, technical assistance should be largely tailored to SBHC needs. Access to certain SBHA resources is available through membership.

- *Create Survey Update Process*

  To help improve and expand data collection and reporting over time, Harbage Consulting recommends that three years after the implementation of the revised Annual Survey, the state and the Council in concert with MASBHC, implement a biennial process for updating it. This would include making decisions about revising and/or removing the data elements that are no longer providing value to the state and adding at least one performance measure for future collection. This will help ensure that the reporting program continues to evolve in a consistent way and is responsive to programmatic changes.

Step 4: Enhance Relationships with Health Plans

Harbage Consulting recommends that SBHCs and health plans develop contracts and a process for sharing information about SBHC enrollees for the purpose of ensuring that children receive needed care, and for demonstrating the value of SBHCs. Given that most children served in SBHCs are Medicaid enrollees, the logical first step is improving connections with Medicaid MCOs; the second step is improving connections with private health plans. It is valuable that health plan representatives sit on the Council and that health plans are sometimes invited to SBHC Administrator meetings, but these meetings need to be more regular.

- *Show Value Proposition for Health Plans*

  The state and the Council should make the case to health plans about the value of collaborating with SBHCs across the state. SBHCs provide health care services to children who are enrolled in health plans and they have information about utilization and quality that health plans and PCPs should want. Health plans have extensive information about children's health utilization and health outcomes that would help SBHCs provide appropriate and non-duplicative care to children, and that would help demonstrate the value of SBHCs. Therefore, the health plan-SBHC relationship can bring mutual value to each entity.

  Medicaid MCOs are required to report HEDIS measures to MDH – not achieving performance measure goals has financial ramifications for them. Medicaid MCOs are also focused on value-based purchasing efforts, such as adolescent well-child visits. Subject to resource availability, MASBHC may be able to offer their expertise in demonstrating to Medicaid MCOs how SBHCs can serve as partners and help them meet their performance goals and save money.[xlviii] Additionally, MASBHC and SBHCs could support Medicaid MCOs with other population health efforts that are underway in Maryland.

  > "If you as an SBHC can help any health plan improve their HEDIS scores, that's value. There are dollars on the line for HEDIS measures and sometimes health plans just fall short of meeting the goals. A couple extra well-child visits can make the difference in paying a chunk of money back to the state or not."
  > – Health Plan Representative

- *Share Information on SBHC Clients*

  We recommend first ensuring there is consistency across the state in the level of information that is being shared between health plans and SBHCs for students that have received services at SBHCs and for whom a reimbursement claim is submitted to their health plan.

  To streamline the Medicaid MCO-SBHC connections across 12 jurisdictions and 84 SBHCs, it would be logistically easier if the state required Medicaid MCOs and SBHCs to share certain information. This could be done by requesting that MDH add language to COMAR regulation 10.09.67.28(C) related to the information that Medicaid MCOs must provide to SBHCs on clients. An alternative is for the state to develop a Business Associate Agreement (BAA) template that could be used by SBHC administrative sponsors and Medicaid MCOs (such that each administrative sponsor, rather than each SBHC, would need an agreement with each MCO). The state should also explore creating connections with private health plans.

However, in order to receive information from Medicaid MCOs, SBHCs must be willing and able to provide information to them. It would be administratively simpler for SBHCs to provide information on a panel of clients (rather than on individual clients). We also recommend exploring the role that CRISP – the state's health information exchange – currently plays and could play in improving care coordination and reducing duplicative services for SBHC clients.

- *Share Information on SBHC Enrollees*

We recommend that the state and Council work with health plans, particularly Medicaid MCOs, to enable the sharing of information about SBHC enrollees (children who are enrolled in an SBHC but have not received services). This practice would be consistent with New York's requirement that Medicaid MCOs and SBHCs share information to improve enrollee health outcomes (see best practices example box). During the 2017 – 2018 school year, 40,551 students enrolled in Maryland SBHCs but only 37 percent received at least one SBHC service. Creating a policy that permits data sharing between SBHCs and health plans about enrollees would likely improve access to, and coordination of, care for approximately 25,470 additional students.

New York Best Practice

In New York, MCOs are required to work with SBHCs to improve enrollee health outcomes. This includes requiring MCOs to use rosters provided by SBHCs to identify enrollees that need comprehensive exams or other services. MCOs are required to provide data to help SBHCs target enrolled children who have not had an annual history and physical exam, and/or other well-child services.

To enroll in a SBHC, parents of children must sign a consent form, which is developed by each county/SBHC. We recommend the development of model language to be added to consent forms, giving permission for SBHCs to inform health plans that their member is enrolled in the SBHC and giving permission for SBHCs and health plans to bi-directionally share information for the purpose of identifying the child's PCP and ensuring their child receives any needed services and treatment. This would enable the health plan to inform the SBHC of which services students need but have not received (e.g., well-child visit, flu shot, etc.) – the SBHC could then conduct targeted outreach to the student to facilitate the provision of these services. Once the health plan is informed that their member is enrolled in an SBHC, they can also proactively reach out and educate their member/their family about the available SBHC services. MASBHC has the appropriate expertise to serve as lead agency for this project. MASBHC or other lead agencies will require adequate financial resources to support such projects.

Since we envision the consent form as the primary way for SBHCs and health plans to be able to communicate about enrollees, SBHCs should work with the schools to enhance their outreach efforts and to encourage people to return the consent form (see additional marketing and outreach recommendations in the last section of the paper – "Improving the Value Proposition for School-Based Health Centers).

- *Share Information on Children Enrolled in Schools with SBHCs*

  Based on our analysis of the Family Educational Rights and Privacy Act (FERPA) and New York's practices (see New York best practice box), we believe that it may be possible for schools to share the name and date of birth of its students with health plans. Under FERPA, schools may disclose without parental consent 'directory' information such as a student's name and date of birth, among other information[xlix] if the school has notified parents that it may do so according to the requirements.[l] Schools with SBHCs would need to revise their annual FERPA public notice to explain which directory information would be shared with health plans for the purpose of treatment and connecting students with needed services.

  Health plans could use the list of children's names and their date of birth to try to identify their members who attend schools with SBHCs. From there, health plans could work with SBHCs to simultaneously outreach to students to encourage them to enroll in the SBHC, and then to support the receipt of needed services and care coordination.

  However, we understand that the state is rightfully concerned about protecting children's privacy. The state would need to decide about whether sharing children's information with health plans meets the public health goals of increasing children's access to needed services. If the state decides not to pursue this strategy, health plans could proactively send communications to their members who are likely in schools that have an SBHC, leveraging member information on their members' age and zip code.

Step 5. Collectively Address Student Information Privacy Concerns

We recommend addressing two key student information privacy concerns – one related to the need to suppress Explanation of Benefits (EOBs) for confidential services and the other related to sharing and disseminating data.

- *Suppress Explanation of Benefits for Confidential Services*

  Recently revised Maryland regulations require Medicaid MCOs to send an EOB to parents when their child's SBHC claim is rejected. This presents a challenge for students who are being seen for confidential services, such as a sexually transmitted infection (STI) or for contraception. Some stakeholders noted they are no longer submitting claims for those services because they do not want to risk an EOB being sent to parents – however, not submitting for reimbursement could hurt the SBHC's revenue. In many other states, including Michigan and New York, Medicaid MCOs are required to suppress

denial notices and EOBs in accordance with the state's policy on confidential health information for minors. The Council and MASBHC should advocate to MDH to make this policy change immediately. This issue needs to be separately addressed with private health plans.

- *Share and Disseminate Data*

  The state and other stakeholders must ensure that data are shared in accordance with all state and federal health and education laws in a manner that appropriately safeguards clients' protected health information (PHI) and education records. This includes adherence to HIPAA, FERPA, where applicable.[li] The lawyers from MSDE, SBHC Administrative sponsors, and Medicaid MCOs (as well as private health plans) need to agree on an approach for ensuring that all requirements are followed. There should be written policies to dictate the access to, and use of, SBHC data.

  Additionally, when publicly disseminating quality measures, stakeholders should be mindful of protecting the confidentiality of clients, particularly in small SBHCs/counties where small numbers are likely. To this end, the state should adhere to guidelines for the release of information with small numerators and small sample size. Additionally, in sharing health and health care data for the purposes of producing aggregate statistics – such as the recommended performance measures – the process of de-identification should be applied to reduce the risks of compromising patients' privacy.[lii]

Phase 2. Data Analysis and Dissemination

Once the data has been collected, Phase 2 involves analyzing the data to produce results that can be used to drive program improvements and to demonstrate the value of SBHCs, and then sharing the findings with the appropriate stakeholders.

Step 1. Consolidate and Analyze the Data

The data collected through the reporting effort will only be as powerful as the states' ability to analyze it, monitor it, and act on the findings. Appendix C lists examples of the types of data results that could be produced based on the recommended and modified performance measures and other Annual Survey questions.

In the short term, Maryland should begin producing baseline performance rates for each MD SBHC and at the state level. Since the data for this reporting effort will likely be housed in different systems, analyses may involve combining datasets to form a more complete dataset to support data analysis. For example, to compare health and educational outcomes at SBHCs versus non-SBHCs, data from the Annual Survey, MSDE, and MDH may need to be analyzed together. Ideally, there would be one system/database that would store all the SBHC data that is reported to MSDE.

The state and Council in concert with MASBHC need to identify who has the expertise, resources, and capacity to conduct this analysis – MSDE, other state staff, the Hilltop Institute,

university researchers, or others – and ensure that the appropriate resources are dedicated to support data analysis and the production of data products. Regardless of which office is responsible for conducting the analyses, they must have staff dedicated to this effort. It would be ideal for the state to be able to conduct the analyses since they understand the context of the program. Alternatively, the state could explore opportunities to leverage local universities to conduct rigorous analyses using all available data sources, but some funding would likely be required to do this (see Maryland best practices box). Currently, the most robust studies on the value of SBHCs in individual states have been conducted by academic researchers.

Maryland Program Best Practice

The Vision for Baltimore (V4B) program is a public-private partnership that provides vision screenings to all children in the Baltimore City School System, and follow-up eye examinations and glasses (as needed) through mobile clinics at schools. V4B partnered with Johns Hopkins University to evaluate the program model and its impact on children's academic performance.

Since our recommended and modified survey performance measures are all currently used in other reporting initiatives, analyses should eventually include comparisons to other states' SBHC initiatives, national benchmarks, and across payers, such as Medicaid. This will help SBHCs and other stakeholders understand current performance and for the state to begin identifying trends, potential quality and access concerns, as well as SBHCs that might have best practices to share with others.

The state should also stratify existing measures by SBHC population subgroups, including demographic characteristics such as race/ethnicity and age. This would allow SBHCs greater insight into their client base to identify and address health disparities that may exist within the population served and move toward health equity.

To facilitate analyses at the state level, MDH should explore whether SBHCs could be given a dedicated site of visit code that could be separate from general school health services and any other services that may be provided in the school setting.[liii] Additionally, Maryland should explore whether its all-payer claims database (APCD), which includes enrollment, provider, and claims data for Maryland residents with private insurance, enrolled in Medicare, and Medicaid MCOs, can be leveraged to compare SBHC costs and performance to other SBHCS, other payers, and across states.

Step 2. Disseminate Data Results

It is important to recognize that the data emanating from the reporting system will serve different purposes for different parties (i.e., SBHC Administrators, MASBHC, the state, Council, state legislature, clients/parents, and the public), and that these purposes may change over time. Although the state should develop a reporting system that can fulfill the full range of data

needs, the information dissemination strategy should be designed to account for the level of information that is appropriate to share with each party.

It will also be important to appropriately frame the data results and to be prepared that the results may not demonstrate the value stakeholders are hoping they will show. It should be made clear that SBHCs are not singularly responsible for the health outcomes and educational outcomes of the children they serve; Children also receive care from PCPs and in other settings, and there is a myriad of other demographic factors that contribute to these outcomes. Therefore, some of the performance measures seek to capture whether children are receiving appropriate health care services, regardless of where the service is provided. Additionally, performance measurement requires reviewing results and making modifications as needed to improve outcomes.

> "Even ugly data is better than no data, and ugly data is more helpful than pretty data."
> – SBHC Stakeholder

We recommend a two- to three- year approach for disseminating the data results to provide time for reviewing the data and handling any data collection, consistency, and/or data analysis issues that may arise. The first year of the enhanced data collection and analysis should be viewed as a learning year and results should only be distributed to MSDE, MDH, MASBHC, SBHC Administrators, and the Council. It should also be accompanied by a webinar that focuses on framing the findings and any data limitations. Once the Council is comfortable with the data, it should work with MSDE and MDH to determine which data should be shared with which stakeholders. MASBHC could play a key role in disseminating this information.

Step 3. Develop Annual Report and Other Data Products

Once the state and SBHCs have confidence in the data analysis results, we recommend that data displays and other products be circulated more widely. The data could be disseminated in the form of fact sheets or reports that provide information and data on key SBHC performance indicators that best demonstrate the value of SBHCs.

Given that it will take some time before the state has information on quality and outcomes, we recommend starting with a simple one-page "Maryland SBHC Fact Sheet" that highlights the information that is already known in order to start marketing the program. It could also highlight data from individual SBHCs that currently exists (but may not be reported to MSDE). Assuming adequate resources can be provided, MASBHC could take an ownership role, in partnership with SBHC Administrators and CASBHC, to develop.

Over time, the document could be expanded to include additional information, year-to-year comparisons, and ultimately become a report. Examples of other state reports that could be leveraged include: Oregon Status Update, Michigan report

Total vaccines given per year in SBHCs (Data source: ALERT IIS)

Target	2014	2015
25,000	20,742	23,340

card, and the Connecticut student satisfaction survey report.[liv] Appendix D includes elements that could be included in a report. SBHC information should also be incorporated into other MSDE and MDH reports.

Phase 3. Data-Driven Technical Assistance and Decision-making

Phase three involves using the data findings to drive technical assistance for SBHCs and decision-making at the SBHC and state levels.

Step 1. Use Data to Drive Technical Assistance, Quality Improvement, and Decision-Making

The results of the data analyses should be used to drive technical assistance and training for SBHCs as well as MSDE, MDH, and SBHC decision-making. Although MSDE currently tries to address issues that are raised by multiple SBHCs by tapping into resources and presenting at SBHC meetings, these efforts could be expanded with the appropriate infrastructure. Technical assistance efforts could be led and/or supported by MASBHC, with considerations for resources needed to provide these efforts. Additionally, data could be used to identify areas of support needs for SBHCs rather than relying solely on individual SBHCs making requests. Elements of a technical assistance approach could include:

- Ad-hoc technical assistance calls/webinars for all SBHCs to address specific issues based on the data trends and SBHC feedback;
- Issue-specific affinity groups that give groups of SBHCs opportunities for technical assistance and to work together toward performance improvement, sharing challenges and best practices;
- Statewide training on issues that are pervasive across many SBHCs; and/or
- Individualized technical assistance to support individual SBHCs on specific issues.

For example, the current CQI Objective requirement could be leveraged to support SBHCs through issue-specific affinity groups. The state and Council could work together to identify a list of areas where quality improvement is needed, and then groups of SBHCs could work toward the same objective. Technical assistance sessions could facilitate dialogue among the SBHCs and include national experts. Maryland could also leverage SBHA and other states' materials on best practices, such as The California SBHA Best Practices Checklist.[lv]

Step 2. Establish Performance Goals and Consider Performance Measurement Incentives

Once there is an understanding of how individual SBHCs and the state are performing, the state and Council should set realistic, but aspirational performance goals for SBHCs. This could include minimum thresholds, year-to-year improvements, and target goals on certain measures, as used in Michigan and Oregon. For example, in Michigan, each SBHC sets a goal for the number of children it will provide services to during the year and at the end of the year they evaluate whether they reached that goal. Michigan also has "threshold goals," which are developed based on a review of the SBHC median score, HEDIS goals, national goals, the state's experience, and efforts to push SBHCs to improve at a realistic rate.

Once performance goals are established, we recommend exploring ways to create performance incentives to encourage and recognize higher performing SBHCs. This could include creating a culture of friendly competition between SBHCs and presenting an award or certificate to the SBHCs that are performing well on or have the greatest improvement on certain metrics. This recognition can be important in fostering a culture of performance measurement and improvement.

PREVENTION AND DISEASE CONTROL QUALITY MEASURES			
METRIC (all values represent the median across CAHCs)	FY 2017	FY 2016	Threshold
Percent of clients with:			
An up-to-date, documented comprehensive physical exam, regardless of where exam provided (n=66)	71%	67%	Reasonable Percentage
An up-to-date risk assessment (n=66)	90%	90%	90%
Complete immunizations for age on date of service, using ACIP recommendations (n=66)	47%	N/A	60%
A diagnosis of asthma who have individualized care plan** (n=65)	89%	77%	100%†

Step 3. Incorporate SBHCs Into State Quality Improvement Efforts

The quality of care should be addressed from a state-level perspective, but also from levels that can address the needs of subpopulations within the state. It appears that SBHCs have been incorporated into some MDH population health goals, but MDH should continue to incorporate SBHCs into state quality improvement efforts, such as the State Managed Care Quality Strategy.

This section of the white paper outlined a myriad of opportunities for creating a data reporting process to demonstrate the value of SBHCs in Maryland. While it is important to collect, analyze, and disseminate information, the goal is for the data to show that SBHCs are making a significant and positive impact on children's health and education outcomes. In the next section, we provide recommendations for how the state can improve the actual value proposition for SBHCs by helping to ensure that the data findings accurately reflect SBHCs' contribution to a high-quality system of care for children.

Improving the Value Proposition for SBHCs

Developing a comprehensive data reporting process is critical to being able to demonstrate the value of SBHCs and to use data to inform technical assistance and drive decision-making. The Council, in collaboration with MSDE and MDH, has been working to improve many areas of SBHC operations and performance. These efforts should continue to be made to improve the actual value proposition for SBHCs. Based on our interviews with stakeholders and our experience working on SBHC issues, children's health issues, and delivery system efforts across the country, below are general recommendations for improving the value proposition for Maryland SBHCs.

Create an SBHC Vision

We recommend that the Council create a vision for the future of SBHCs and make decisions about whether and how it wants to integrate SBHCs into the broader health care system. As conversations continue to take place in the state regarding delivery system transformation, the importance of preventive services, and bringing services to people, what should the role of SBHCs be? Should SBHCs be able to serve as a child's PCP? Should SBHCs provide health care services to parents, school employees, and/or the broader community?

Invest in State SBHC Infrastructure

Maryland must invest in SBHCs to yield positive outcomes and to realize the full potential impact of SBHCs on children's lives. This includes ensuring that the appropriate levels of funding are dedicated to state SBHC administration and to individual SBHCs. Additional staff will be needed if the state decides to implement the recommendations in this report, as well as other operational and oversight tasks. Additionally, greater collaboration is needed between MSDE and MDH and with partners.

- *State Funding*

  The State of Maryland annually provides $2.6 million in state general funds to support 73 of the 84 SBHCs.[lvi] Data from the SBHA shows that state funding for SBHCs in Maryland has declined by 34 percent since FY 2002 (from $3,949,941).[lvii] This trend seems to be in stark contrast to the level of need among low-income students in Maryland and the level of demand in local communities. In fact, at least one additional county is planning to establish SBHCs next year and other counties have expressed interest to MSDE in opening new SBHCs.

  The level of state funding for SBHCs in Maryland is lower than in many other states. Table 3 below lists some of the states that provide funding to SBHCs, the number of SBHCs that are funded, the total number of SBHCs, and the total state funding.[lviii]

Table 3. State Funding for SBHCs			
State	Number of SBHCs Funded	Total Number of SBHCs	Total State Funding ($)
Michigan	111	111	22.0 million
Louisiana	64	70	8.7 million
Oregon	65	65	6.8 million
Delaware	29	29	5.2 million
Illinois	41	60	4.1 million
New Mexico	52	72	3.5 million
Massachusetts	34	52	3.0 million
Maryland	78	84	2.6 million
District of Columbia	6	6	2.0 million

If the goal is to increase the value of SBHCs to Maryland's delivery system, the state will need to invest more resources. We recommend that the Council, MASBHC, MSDE, and MDH advocate to the state legislature to create a budget line item specifically dedicated to funding SBHCs. MASBHC is ideally leveraged to advocate for increased funding because they can lobby. In seeking additional state funding, it will be critical to be specific about what the funding would be used for. We also recommend that any additional state funding be directed to improving state capacity and ensuring the financial viability of existing SBHCs before funding new SBHCs. Additionally, Maryland should also explore other funding options (e.g., health plan foundations, Health Resources & Services Administration Maternal and Child Health grant funding).[lix]

- *State Infrastructure and Collaboration*

We recommend the state establish a School-Based Health Center Program Office that would be responsible for administering and overseeing all aspects of SBHCs. Eighteen states have a School-Based Health Center Program Office that is devoted entirely to the administration of SBHCs.[lx] These Program Offices are typically administered by the state's Health, Medicaid, or Public Health Agency. This structure enables states to better integrate SBHCs with other state quality improvement and delivery system transformation efforts. Ideally, the Maryland office would be jointly staffed by MSDE and MDH with staff reporting up through their respective agency's line of authority.

We recommend that the Council facilitate the identification of all the tasks that MSDE, MDH, and the Council currently conduct in support of SBHC administration, as well as additional responsibilities the state and others identify. This list of tasks could be used to determine which state agency is most qualified to conduct each activity, which would

inform state staffing and resource decisions and ultimately improve interagency collaboration and capitalize on the full range of state expertise.

Improve the Maryland SBHC Model

We recommend that the Council further analyze opportunities for improving the SBHC model in Maryland, which differs from other states. In Maryland, Local Health Departments serve as the sponsoring agency for approximately 70 percent of SBHCs,[lxi] compared to eight percent nationally.[lxii] Nationally, 51 percent of SBHCs are administered by FQHCs and hospitals are the second most common sponsor.[lxiii] In Oregon – a state that is considered a leader in SBHCs – 77 percent of its SBHCs are administered by FQHCs.[lxiv] In New York, 40 percent of SBHCs are sponsored by hospitals.[lxv]

FQHCs are a logical home for SBHCs – they have existing infrastructures, experience serving vulnerable populations, and receive more favorable Medicaid reimbursement rates. Relying more on FQHCs to serve as the sponsoring agency for SBHCs could reduce SBHC start-up costs and be a more financially viable model in the long run. Currently, hospitals are not permitted to receive Medicaid reimbursement for SBHC services, but this is something that should be reviewed, leveraging experiences from other states.

Additionally, the Maryland SBHC standards need to be revisited since they have not been updated since they were released in 2006. The Council has efforts under way to make recommendations on changes to the standards. As part of this effort, the Council should develop standards for determining which areas of the state have the highest unmet health care needs and therefore are appropriate for housing an SBHC. Updating the standards should be informed by stakeholder feedback and the standards in other states (e.g., Oregon, Louisiana, Michigan, and New Mexico).[lxvi] The standards should identify the requirements that SBHCs in the state should meet and should not be retrofitted to meet current SBHC practices.

Improve Connections with Primary Care Providers

We recommend that the Council and SBHCs make a dedicated effort to improving bi-directional connections with PCPs to better coordinate care, reduce duplication of services, and to improve data sharing across providers. We also recommend that the state revisit the current COMAR regulations regarding SBHC communication with PCPs to assess how they are working in practice, and work with PCP associations to create a standardized process for SBHC-PCP communications.[lxvii] In New York, there are minimum requirements for SBHCs to communicate with PCPs when a student enrolls in the SBHC and requirements for policies and procedures to strengthen the services of PCPs while avoiding service duplication (see New York best practice box).[lxviii]

New York Best Practice

SBHCs must initiate a written communication process with PCPs including: Notification the student has enrolled in the SBHC; The scope of services offered by the SBHC; and a Request for the student's health records and current treatment plan.

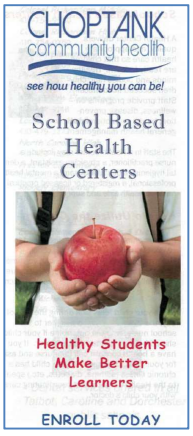
Some SBHC providers expressed that some PCPs view SBHCs as a threat to their work and revenue, particularly in small and rural counties. Michigan has faced the same challenge but found that PCPs quickly recognize how SBHCs help their practice. Michigan reported that PCPs experienced an increase in clients due to referrals from SBHCs both for students who did not previously have a PCP and for follow-up services. PCPs ended up spending less time with children whose health issues did not require their attention and more time with children who needed them. The state, Council, and Maryland American Academy of Pediatrics could conduct outreach and education to PCPs on the services SBHCs provide, how PCPs and SBHCs can coordinate, and how SBHCs can be helpful to PCPs – with the ultimate shared goal of improving children's health.

Conduct Marketing and Outreach

In addition to conducting outreach to PCPs, the value of SBHCs needs to be marketed to students and parents. Many students and parents are unaware of the services that SBHCs can offer. One SBHC sponsoring agency noted that they wished they had an outreach person to facilitate getting SBHC enrollment forms signed. Outreach strategies are key to increasing enrollment in public programs and SBHCs are no exception.

> "SBHCs are a key piece of the safety net but they are underutilized for their potential to be an access point for children who might otherwise not have access to services." -Stakeholder

During the 2017 – 2018 school year, only 37 percent (15,081 out of 40,551) of children who were enrolled in an SBHC received at least one service.[lxix] However, these statistics vary by SBHC. For example, while Montgomery County enrolls a larger number of children in SBHCs (18,422), only 15 percent of them actually received services. On the other hand, in Talbot County, 86 percent of SBHC enrollees received services[lxx] and in Dorchester County, 81 percent of the school population is enrolled in an SBHC and 47 percent of enrollees received services.[lxxi] The SBHCs we interviewed noted they have the capacity to serve more students, but some SBHCs would need additional funding to hire staff to accommodate additional clients.



Choptank Health recognizes the importance of marketing and has a series of brochures on their SBHC programs. In Louisiana and New York, SBHCs and schools are required to work together to publicize SBHC services to the student body. Some states, such as Oregon and the District of Columbia have one-page marketing materials.[lxxii] We recommend that Maryland develop similar policies and materials. The state could also identify strategies for incentivizing the return of enrollment forms (e.g., teacher competitions and rewards for most returned forms). Individual SBHCs could be encouraged to establish goals for the share of the student body who enrolls in the SBHCs.

Increase Collaboration with Health Plans to Improve Effectiveness of SBHCs

Efforts should continue to be made to ensure that SBHCs are maximizing Medicaid billing. MDH regulations should be revised to permit Medicaid reimbursement for services provided to Medicaid-enrolled teachers, school employees, siblings, parents, and members of the community. Additionally, as SBHCs start to incorporate telehealth models, MDH should work with them to ensure appropriate reimbursement (which may involve exploring revising Maryland Medicaid policies).

Efforts should also be made at the state level to try to improve connections between SBHCs and private health plans, rather than requiring each county or SBHC to separately approach each private health plan. Other states have found that it is critical to show private health plans the critical mass of their members who are receiving services in SBHCs across the state. It is also important to explain to health plans what services are provided in SBHCs, since these are services that private health plans would cover if the services were received in a different setting.

Engage Students and Parents

We recommend engaging students and their parents in SBHC strategic planning and enlisting their help in demonstrating the value of SBHCs. For example, New Mexico requires that SBHCs maintain or participate in a school or district level School Health Advisory Council that meets at least twice during the academic year and requires the membership of at least two youth. The meeting agenda must specifically address and support SBHC operations and activities.[lxxiii]

Conclusion and Next Steps

This white paper lays out a detailed roadmap for developing a data reporting process to demonstrate the value of SBHCs in Maryland. It will take time, effort, and collaboration to fully achieve this goal. However, the end result of having information about the program and using it to drive decision-making and SBHC improvements will be critical to ensuring that SBHCs are maximizing their impact on children's health and education and reducing costs across the state.

While this reporting process is being designed and implemented, the Council should work with the state to begin to tell the Maryland SBHC story using existing information and data. The Council should also continue to pursue opportunities for improving the value proposition for SBHCs to help ensure that the data findings accurate reflect that SBHCs contribute to a high-quality system of care for children. The SBHCs know that they play a critical role for children – now is the time to show that to children, parents, stakeholders, the legislature, and the public.

Appendix A. National and State Performance Measurement Efforts

The national SBHA and some states are increasingly focused on improving SBHC data collection, analysis, and dissemination to further the evidence base for SBHCs. Below are summaries of these efforts.

National SBHA Performance Measurement Initiative

In 2015, the SBHA began an initiative to collect performance measures from SBHCs to demonstrate their value. Through a multi-stakeholder review process, the SBHA selected the following core set of five standardized, evidence-based clinical performance measures for voluntary adoption and reporting by SBHCs:

- Annual Well-Child Visit;
- Annual Risk Assessment;
- Body Mass Index (BMI) Assessment and Nutrition and Physical Activity Counseling;
- Depression Screening and Follow-Up Plan; and
- Chlamydia Screening.

The SBHA set a goal of having 100 percent of SBHCs nationwide report on these measures; currently 22 percent of SBHCs are reporting at least one measure. Since these five measures also align with measures used in other national reporting efforts, including the Healthcare Effectiveness Data and Information Set (HEDIS) and the CMS Medicaid/CHIP Core Set of Children's Health Care Quality Measures (Child Core Set) for state reporting, SBHC reporting on the measures will enable comparisons to SBHCs in their own states and nationally, as well as across payers. The SBHA has also developed a wide range of technical assistance efforts around the measures, including detailed measure technical specifications, webinars, and downloadable performance measurement reports.

Other States

Below are snapshots of two states – Oregon and Michigan – that are leading the way on improving data collection and analysis to assess the value of SBHCs.

Michigan

Michigan's Child and Adolescent Health Center (CAHC) program is jointly administered by the Michigan Department of Health and Human Services and the Michigan Department of Education. The Department of Education receives state funding, but the state SBHC staff work for the Department of Health and Human Services. There are four full-time state staff dedicated to SBHC administration and six part-time consultants that provide expertise in a range of areas including clinical and evaluation support.

There are 111 state-funded CAHC sites in Michigan, serving over 30,000 children and adolescents. The program currently collects data on several standardized measures from CAHCs, including information on well-child visits, immunizations, and sexual health. Statewide results are published in an annual report card and are compared to desired performance thresholds to contextualize the findings. The state also sends each SBHC their own individualized report card, which compares their score to the statewide results. The Michigan measures appear to encompass the SBHA measures, with some variation.

Key Factors Leading to Michigan Performance Improvements

- More frequent and intensive training and technical assistance to increase provider understanding and comfort level
- Support for Michigan efforts through national initiatives and incentive programs to measure quality
- Improved familiarity for providers on the capabilities of their electronic health records systems

CAHCs are also required to implement a continuous quality improvement plan for physical mental health services, that includes a: 1) practice and record review conducted at least twice a year; 2) needs assessment conducted within the last three years; and 3) annual client satisfaction survey. The state notes that there has been a noticeable improvement in performance since the implementation of quality measurement in CAHCs.[lxxiv]

Oregon

Oregon's SBHC program is administered by the School-Based Health Center Program Office, which is within the Public Health Division in the Oregon Health Authority. There are state-developed certification standards to help reduce variability between SBHC sites across the state. While certification is voluntary, only certified SBHC are eligible for funding from the Oregon Health Authority. As of July 2018, there were 76 certified SBHCs in 25 counties across the state.

All certified SHBCs must meet five data reporting requirements: 1. Visit/encounter data; 2. Patient satisfaction surveys; 3. Billing/revenue and funding information; 4. Staffing and hours of operation; and 5. Key Performance Measures (KPMs).

Certified SBHCs must report on two KPMs – Well-Child Visit and Comprehensive Health Assessment – and one of five optional KPMs: Adolescent Immunization, Chlamydia Screening, Depression Screening, Nutrition Counseling, and Substance Use Screening. Each measure has a detailed measure technical specification for reporting, including inclusion and exclusion criteria. Like in Michigan, the Oregon measures appear to encompass the SBHA-recommended performance measures.

Appendix B. Recommended Performance Measures

This appendix provides details on the recommended performance measures – including the measure name, measure steward, definition, the rationale for collecting the measure, and the quality measurement reporting efforts with which each measure aligns. The sources for the measure technical specifications can be linked to and found in the endnotes.

Measure Name (measure steward)	Definition	Rationale	Measure Alignment
Primary and Preventive Care			
Annual Risk Assessment[lxxv] (SBHA)	Percentage of unduplicated SBHC clients with documentation of ≥1 age-appropriate annual risk assessment during the school year, regardless of where the assessment was conducted.	Children and adolescents should annually be assessed to gauge potential environmental, social, emotional, and behavioral threats to their wellbeing; create opportunities to intervene early; and organize a response for students who are at highest or immediate risk for harm	SBHA-recommended performance measures
	Percentage of unduplicated SBHC clients ages 12 and above with documentation of ≥1 age-appropriate annual risk assessment during the school year		
Depression Screening & Follow-Up[lxxvi] (SBHA modification of CMS)	Percentage of unduplicated SBHC clients aged ≥12 years with documentation of the following at least once during the school year, regardless of where the screening was conducted: • Screened for clinical depression using an age appropriate standardized tool AND • Follow-up plan documented if positive screen	The U.S. Preventive Services Task Force recommends that adolescents be screened for depression using a validated questionnaire, and only when systems are in place for diagnosis, treatment, and follow-up	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set
Care of Acute and Chronic Conditions			
Asthma Action Plan (N/A)	The percentage of unduplicated SBHC clients identified as having asthma who have an asthma action plan documented in their health record, regardless of which provider developed the plan with the client/parent (including non-SBHC providers).	The Centers for Disease Control and Prevention recommends that all people with asthma have an action plan describing how to control asthma long term, and that all people who care for a child with asthma know about the child's plan	N/A

Measure Name (measure steward)	Definition	Rationale	Measure Alignment
Asthma Medication Ratio[lxxvii] (NCQA/HEDIS)	The percentage of SBHC clients ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the school year	Appropriate ratios for these medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits, missed work and school days)	CMS Medicaid/CHIP Child Core Set; HEDIS
Emergency Department Visits[lxxviii] (Modification of NCQA/HEDIS)	Rate of emergency department visits per 1,000 member months among SBHC clients up to age 19 who are enrolled in Medicaid/MCHP/Private health plans	Unnecessary visits to a hospital emergency department may indicate lack of access to more appropriate sources of medical care, such as primary care providers or specialists	CMS Medicaid/CHIP Child Core Set; HEDIS
Care Coordination			
Timely Transmission of Health Visit Report (N/A)	The percentage of SBHC clients who needed follow-up care with their primary care provider (PCP) whose health visit report was transmitted to the PCP within 7 days of the SBHC health visit.	Care coordination can help improve the safety, efficiency, and effectiveness of health care. COMAR regulations include standards for ensuring the timeliness of coordination between SBHCs and patients' primary care providers	N/A
Educational Outcomes			
Classroom Seat Time Saved[lxxix] (SBHA test measure)	Can be measured three ways: • The percent of SBHC visits that result in sending students back to class rather than to their homes or a hospital, emergency room, or external health care provider • The total hours of the remaining school day students save once they are sent back to class after visiting the SBHC • The average time of a visit to the SBHC versus the amount of time it would take students to seek care from an external health care provider	Students with accessible health services, can have their health issues addressed in real-time and sent back to class, rather than be sent home	SBHA test measure

Measure Name (measure steward)	Definition	Rationale	Measure Alignment
Cost and Budgets			
Operating Income[lxxx] (California SBHA)	Net annual revenue – Net annual operating costs Annual Revenue: • Federal: • State: • Local: • Foundation: • Private donation: **Net Annual Revenue** Annual Operating Costs: • Salary and Wages: • Fringe benefits: • Contracts: • Training: • Utilities & Maintenance: • Equipment: • Travel: • Supplies and Materials: **Net Annual Operating Costs**	Understanding the cost effectiveness of SBHCs can help identify SBHCs that are operating inefficiently and identify where additional investments may be needed	California SBHA

Appendix C. Recommended Modifications to Annual Survey Performance Measures

This appendix provides recommendations for modifying some performance measures that are currently in the revised Annual Survey to align with other performance measurement efforts. It includes the current Annual Survey data element (and the question number), the recommended performance measure, measure steward, definition, the rationale for collecting the measure, and the quality measurement reporting efforts with which each measure aligns. The sources for the measure technical specifications can be linked to and found in the endnotes.

Current Survey Data Element / Recommended Performance Measure (measure steward)	**Definition**	**Rationale**	**Measure Alignment**
Well-Child Exams (question #25) / Annual Well-Child Visit[lxxxi] (SBHA)	Percentage of unduplicated SBHC clients 0-21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the school year **Note:** Two percentages are calculated for this measure: 1. Well-child visits provided by the SBHC; and 2. Well-child visits provided by non-SBHC providers.	The American Academy of Pediatrics and Bright Futures recommend a comprehensive annual preventive visit at ages 3, 4, 5, and 6, and annual well-care visits during adolescence	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set; HEDIS
BMI >85% (question #26) / BMI Assessment & Nutrition/Physical Activity Counseling[lxxxii] (SBHA modification of NCQA/HEDIS)	Percentage of unduplicated SBHC clients aged 3-17 with documentation of the following at least once during the school year, regardless of where the services were provided: • BMI percentile AND • Counseling for nutrition AND • Counseling for physical activity Percentage of unduplicated SBHC clients aged 3-17 with BMI ≥85th percentile with documentation of the following at least once during the school year: • BMI percentile AND • Counseling for nutrition AND • Counseling for physical activity	Children and adolescents should be screened at least annually for body mass index (BMI), according to the U.S. Preventive Services Task Force. Patients with a high or increasing BMI should be counseled on nutrition and physical activity to encourage healthy weight	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set; HEDIS

Current Survey Data Element / Recommended Performance Measure (measure steward)	Definition	Rationale	Measure Alignment
Chlamydia/ Gonorrhea Screening (question #26) Chlamydia Screening[lxxxiii] (SBHA modification of NCQA/HEDIS)	Percentage of unduplicated SBHC clients (male or female) identified as sexually active who had ≥1 test for Chlamydia documented during the school year, regardless of where the screening was provided **Note:** Percentages are calculated separately for males and females.	The Centers for Disease Control and Prevention recommends screening all sexually active females under 25 years of age for Chlamydia and also consider screening high risk adolescent males	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set; HEDIS
Vaccines Given (question #26) / Immunizations for Adolescents[lxxxiv] (NCQA/HEDIS)	Percentage of adolescent SBHC clients age 13 who had documentation of one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday, regardless of where the vaccines were provided	Recommended well care for adolescents includes reviewing their immunization history to ensure they are up to date on their vaccines	CMS Child Core Set; HEDIS
Oral Health (question #31) / Dental or Oral Health Services[lxxxv] (CMS)	Percentage of unduplicated SBHC clients under age 21 who received at least one oral health service during the school year provided by either a somatic or oral health provider, regardless of where the service was provided	Untreated/undetected oral health issues can negatively affect a child's physical and social development and school performance	Form CMS-416 (Annual EPSDT report)

Appendix D. Potential Maryland SBHC Report Elements

The following elements could eventually be included in reports on Maryland SBHCs. The state and the Council would decide which data elements would be shared with each stakeholder (i.e., MSDE, MDH, Council, SBHC Administrators, legislature, the public). We recommend first focusing on individual SBHC and state year-to-year changes in performance. Over time, individual SBHC performance could be compared to the state average, national benchmarks, and across payers.

Overview of SBHCs

- Define SBHCs and identify commonly provided services and qualified providers
- Identify administration of SBHCs – % that are Local Health Departments, FQHCs, Other
- Number of SBHCs across the number of jurisdictions (identify jurisdictions)
- Number of children at schools with an SBHC to demonstrate potential access to SBHCs
- Percentage of SBHCs at elementary schools vs. junior high schools vs. high schools
- Number and percentage of SBHCs in health professional shortage areas (MDH)
- Number and percentage of SBHCs using Electronic Medical/Health Records (EMR/EHR)
- Number and percentage of SBHCs with one of the following provider types: nurse practitioner, doctor, physician's assistant, mental health provider, dental provider
- Percentage of Vaccine for Children providers that are SBHCs

Utilization of Services

- Populations served in addition to students (e.g., school employees, teachers, siblings, parents, community members)
- Percentage of the school's student population that is enrolled in the SBHC
- Number of students enrolled in SBHCs – total and by county
- Number of unique students who received care at SBHCs
- Total number of SBHC visits and average number of visits per student
- Percentage of visits that were for somatic care, behavioral health, dental health, or other services
- Emergency Department Visits: There were X emergency department visits per 1,000 member months among children in Medicaid/MCHP/private health plans enrolled in SBHCs

Demographic Information

- Insurance status of SBHC clients
- Distribution of SBHC enrollees and clients by race
- Distribution of SBHCs enrollees by age

Quality of Care

Health Outcomes

- Annual Risk Assessment: X% of MD SBHC clients who had an annual risk assessment during the school year
- Annual Well-Child Visit: X% of MD SBHC clients age under age 21 had at least one well-child visit during the school year (stratify by age); X% of MD SBHC adolescent clients had at least one well-child visit during the school year
- Depression Screening and Follow-Up: W% of MD SBHC clients who were screened for clinical depression and had a follow-up plan documented
- Asthma Action Plan: X% of MD SBHC clients with asthma who have a documented asthma action plan in their health record
- Asthma Medication Ratio: X% of children served in SBHCs with persistent asthma had a ratio of controller medication to total asthma medications of .50 or greater
- BMI Assessment & Nutrition/Physical Activity Counseling: V% of children age 3 – 17 served in MD SBHCs who had their BMI percentile, and counseling for nutrition and physical activity, documented in their medical record
- Chlamydia Screening: X% of sexually active SBHC clients who were screened for chlamydia
- Immunizations for Adolescents
    a. X% of MD SBHC clients age 13 who were up-to-date on Combination 1 immunizations compared to:
    b. Y% of MD SBHC clients that have completed the human papillomavirus (HPV) vaccine series by their 13th birthday
- Any Dental or Oral Health Service: X% of MD SBHC clients who received at least one dental/oral health service during the school year compared to Y% of children enrolled in Medicaid and CHIP

Care Coordination

- Timely Transmission of Health Visit Record: X% of SBHC clients who needed follow-up care with their primary care provider (PCP) had their health visit report transmitted to the PCP within 7 days of the SBHC health visit.

Education Outcomes

- Classroom Seat Time Saved: X% of MD SBHC client visits resulted in sending students back to class versus their homes, a hospital, emergency room, or external provider

- Chronic Absenteeism:
  a. W% of MD SBHC clients missed at least 10 percent of school days in the year compared to X% of students in the same schools who are not SBHC clients

  b. Y% of students in schools with an SBHC missed at least 10 percent of school days in the year compared to Z% of students in schools without an SBHC

Cost Savings

- Average cost per Emergency Department Visit (MDH)

Client Experience

- Results of client satisfaction survey – e.g., Estimated class time missed by students for health care appointments (SBHC care vs. non-SBHC care) (i.e., missed none or only part of a class vs. missed all day), clients' ability to get care when needed, ratings of provider communication, and client health status.

Funding and Costs

- Annual state funding amount for SBHCs
- Distribution of funding sources - % State, % Medicaid reimbursement, federal grants, local, foundation, private, in-kind, other
- Total annual Medicaid claims for SBHC services (MDH)
- Range of annual SBHC costs and revenues
- Operating Income: Average operating income across MD SBHCs
- Average cost per Emergency Department Visit (MDH)
- Cost savings associated with reductions in emergency department use
- Savings in time and income to parents of children enrolled in SBHCs

- For every state dollar invested, SBHCs leveraged an estimated additional $X from grants, billing, donations, and other sources.

SBHC Highlights

- Highlight innovative things individual SBHCs are doing (qualitative information from SBHCs)

Appendix

- List of all SBHCs by county

Endnotes

[i] Maryland SBHC Standards
[ii] Council on Advancement of School-Based Health Centers, 2017 – 2018 Annual Report.
[iii] Council on Advancement of School-Based Health Centers, 2017 – 2018 Annual Report.
[iv] Communication with MSDE on October 31, 2018.
[v] House Bill 375. Approved by the Governor on May 12, 2015. Available at: http://mgaleg.maryland.gov/2015RS/chapters_noln/Ch_417_hb0375E.pdf.
[vi] Based on Harbage Consulting analysis of MD SBHC contact information for SBHC sponsoring agencies, available at: http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SBHC/SBHCContactListFY19.pdf.
[vii] Level I: Core School-Based Health Center A Level I SBHC site must have hours that are at a minimum eight hours per week with a licensed medical clinician present and are open a minimum of two days per week when school is open. Level I SBHC staff must include, at a minimum, a licensed medical clinician and administrative support staff. There may be additional clinical support staff such as a RN, LPN, or CNA. Note: the licensed medical clinician cannot replace the school nurse.
Level II: Expanded School-Based Health Center The SBHC site must be operational (with an advance practice provider on site) a minimum of twelve hours per week, three to five days for medical care when school is in session. Mental health services must be available on site for a minimum of three days and a minimum of twelve hours per week. The SBHC staff must include at a minimum: A licensed medical clinician; Mental health professional; Clinical support staff (RN, LPN, or CNA); and Administrative support staff. Level III: Comprehensive School-Based Health Center Medical services must be available a minimum of five days and twenty hours per week. The availability of full-time services needs to be commensurate with the number of students enrolled in the school. The SBHC may rely on other community healthcare providers for 24-hour coverage.
Level III or Comprehensive SBHC is available limited hours for defined services for enrolled students during the summer hours. The SBHC is open before, during, and after school hours. The SBHC staff must include at a minimum: A licensed medical clinician; Clinical support staff (RN, LPN, or CNA); Administrative support staff; Mental health professional; and at least one additional service provider such as a general or pediatric dentist, dental hygienist, nutritionist, or health educator for a minimum of four hours per month. SBHC Standards.
[viii] Analysis of data from Council on Advancement of School-Based Health Centers, 2016 – 2017 Annual Report, p. 9.
[ix] Communication with MSDE on October 31, 2018.
[x] Communication with MDH on September 25, 2018.
[xi] Cite regulation and Maryland Medicaid School-Based Health Center Provider Manual: A Comprehensive Guide on CMS-1500 Billing Procedures for School-Based Health Centers. Updated May 24, 2018.
[xii] Maryland COMAR 10.09.76.04. Available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.76.04.htm.
[xiii] Maryland Medicaid School-Based Health Center Provider Manual, May 2018. Available at: https://mmcp.health.maryland.gov/SiteAssets/pages/Provider-Information/SBHC_Provider_Manual_05.24.2018.pdf.
[xiv] Maryland SBHC Standards and communication with MSDE.
[xv] Maryland COMAR 10.09.76.03
[xvi]Knopf, J. et al. and the Community Preventive Services Task Force. School-Based Health Centers to Advance Health Equity: A Community Guide Systematic Review. American Journal of Preventive Medicine. July 2016; 51(1): 114-126. Available at: https://www.thecommunityguide.org/sites/default/files/publications/he-ajpm-evrev-sbhc.pdf.
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[xxviii] Knopf, J. et al., 2016.
[xxix] Knopf, J. et al, 2016.
[xxx] McNall, M et al., July 2008. Michigan Evaluation of School-Based Health (MESH) Study. Michigan State University. Summary available at: https://www.michigan.gov/documents/mdch/MESH_Project_Brief_Final_375932_7.pdf. Full study is available at: https://cerc.msu.edu/upload/documents/MESH_2008.pdf.
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[xxxvi] Oregon School-Based Health Centers: Status Report, 2018.
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[xli] NCQA HEDIS and Performance Measurement. Available at: https://www.ncqa.org/hedis/.
[xlii] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[xliii] School-Based Health Alliance Performance Measures: Quality Counts Initiative. Available at: https://www.sbh4all.org/current_initiatives/nqi/.
[xliv] California School-Based Health Alliance Key Performance Measures for School-Based Health Centers. Available at: http://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2014/10/CSHA-Key-Performance-Measures-for-SBHCs.pdf.
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[xlvi] Michigan Child and Adolescent Health Centers Quarterly Reporting Data Elements Definitions, Effective October 1, 2018. Available at: https://www.michigan.gov/documents/mdhhs/CAHC_Report_Definitions_610330_7.pdf

[xlvii] School-Based Health Alliance. Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf. School-Based Health Alliance Quality Counts Webinars. Available at: https://www.sbh4all.org/current_initiatives/nqi/quality-counts-webinars/. School-Based Health Alliance. Preparing to Participate: General Tips. Available at: https://www.sbh4all.org/current_initiatives/nqi/preparing-to-participate-general-tips/.

[xlviii] In addition to the HEDIS measures in the recommended and modified performance measures set, SBHCs could also support Medicaid MCO efforts to improve on HEDIS measures including: Childhood Immunization Status, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, and Medication Management for People with Asthma. See Medicaid MCO HEDIS measures at: https://mmcp.health.maryland.gov/healthchoice/Documents/2017-09-27%20-%20HEDIS%20Executive%20Summary%20Report%20-%20Updated%20(3).pdf.

[xlix] 34 CFR 99.3

[l] 34 CFR 99.37

[li] More information about HIPAA and FERPA, including the interplay between the federal laws, is available in a U.S. Department of Health and Human Services and Department of Education's *Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records*.

[lii]For example, in New Mexico, student data that is exported can only be in aggregate form in a flat, delimited file with a unique identifier other than the student's name.[lii] HIPAA allows for the use and disclosure of de-identified data (since it is no longer considered personally identifiable information/personal health information), and permits two de-identification approaches. It is important for SBHC partners to be mindful that even properly de-identified data are not completely free from risk, and that other processes may need to be considered (e.g., encryption, data sharing agreements) to help manage and protect de-identified information. HIPAA requirements are available at: https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html#rationale.

[liii] The following SBHA website has policy documents from three other states that require Medicaid MCOs to reimburse SBHCs for covered services: https://www.sbh4all.org/advocacy/medicaid-policies-that-work-for-sbhcs/.

[liv] Oregon School-Based Health Centers Status Update 2018. Oregon Health Authority. Available at: https://apps.state.or.us/Forms/Served/le8926.pdf. Michigan Child and Adolescent Health Center FY27 Report Card. Available at: https://www.michigan.gov/documents/mdhhs/CAHC_FY17_Report_Card_620687_7.pdf.

[lv] California School-Based Health Alliance School-Based Health Center Best Practices Checklist. Available at: https://www.schoolhealthcenters.org/sbhc-best-practices-checklist/.

[lvi] Communication with MSDE on October 31, 2018.

[lvii] National School-Based Health Alliance. Table 4. States with Ten-plus Years Investment in SBHCs, FY2002, 2008, 2014 – Data from 2013-2014 school year. Available at: http://www.sbh4all.org/wp-content/uploads/2016/11/policy-survey-2014-executive-summary-FINAL.pdf. Note that this survey shows state funding of $2.8 million for school year 2013 – 2014, which is slightly higher than the MSDE-produced state funding amount of $2.6 million for school year 2018 - 2019.

[lviii] National School-Based Health Association. Available at: https://www.sbh4all.org/school-health-care/aboutsbhcs/school-based-health-care-state-policy-survey/. Data for Michigan is based on communications with the Michigan Department of Health & Human Services.

[lix] Other states – Connecticut, Illinois, Indiana, New York, and Texas – leverage the federal Health Resources & Services Administration (HRSA) Maternal and Child Health grant funding. Some states provide incentives to Medicaid MCOs to contract with public health providers such as SBHCs (e.g., Minnesota and West Virginia) as a supplement to their monthly capitation payments.

[lxi] Based on Harbage Consulting analysis of MD SBHC contact information for SBHC medical sponsor, available at: http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SBHC/SBHCContactListFY19.pdf.
[lxii] National School-Based Health Alliance 2013-2014 Census Report - Health System Partnerships. Available at: http://censusreport.sbh4all.org/.
[lxiii] Communication with National School-Based Health Alliance. National School-Based Health Alliance 2013-2014 Census Report. Available at: http://censusreport.sbh4all.org/.
[lxiv] Oregon School-Based Health Centers Status Update, 2018. Available at: https://apps.state.or.us/Forms/Served/le8926.pdf.
[lxv] New York School-Based Health Centers Fact Sheet. Available at: https://www.health.ny.gov/statistics/school/skfacts.htm.
[lxvi] Oregon Standards for Certification-Version 4. Available at: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Documents/SBHC%20Certification/SBHCstandardsforcertificationV4.pdf. Louisiana Principles, Standards, and Guidelines for School-Based Health Centers in Louisiana. Available at: http://ldh.la.gov/assets/oph/pcrh/adolescent/2012-13DocumentsAndForms/Principles_tandards_and_Guidelines_7-2012_FINAL.doc. Michigan Minimum Program Requirements. Available at: https://www.michigan.gov/documents/mdch/Minimum_Program_Requirements_1014_FINAL_475622_7.pdf. New Mexico Standards and Benchmarks for School-Based Health Clinics. Available at: http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Rules%20and%20Statutes/Medical%20Assistance%20Division/2015-2016%20NM%20Standards-final.pdf.
[lxvii] In New York, when a student enrolls in the SBHC and the student's PCP is an outside entity, the SBHC must initiate a written communication process. "At a minimum, this should include: Notification that the student has enrolled in the SBHC; The scope of services offered by the SBHC; A request for the student's health records, including the most recent physical exam, history, and current treatment plan, along with the transmittal of the appropriate medical release authorization form." Additionally, SBHCs must have policies and procedures in place to "strengthen the services of the PCP by fostering comprehensive and coordinated health care delivery while avoiding service duplication. Topics to be addressed in these policies and procedures include: Appropriate information and sharing of medical records; Mechanisms to ensure confidentiality; Referral for specialty care; and Coordination of treatment." New York Principles and Guidelines for School Based Health Centers in New York. Available at: https://www.health.ny.gov/facilities/school_based_health_centers/docs/principles_and_guidelines.pdf.
[lxviii] Principles and Guidelines for School Based Health Centers in New York State. Available at: https://www.health.ny.gov/facilities/school_based_health_centers/docs/principles_and_guidelines.pdf.
[lxix] Council 2017 – 2018 Annual Report.
[lxx] Council 2017 – 2018 Annual Report.
[lxxi] Dorchester County FY 2018 Report.
[lxxii] Oregon – Available at: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Documents/SBHC__Pubs/SBHC.GenFactSheet_ENGLISH.pdf. District of Columbia – Available at: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/SBHC%20Fact%20Sheet%20ENG.pdf.
[lxxiii] New Mexico SBHC Standards. Available at: http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Rules%20and%20Statutes/Medical%20Assistance%20Division/2015-2016%20NM%20Standards-final.pdf.
[lxxiv] https://www.michigan.gov/documents/mdhhs/FY15CAHC_DashboardFinal_545015_7.pdf.
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[lxxvi] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

[lxxvii] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxviii] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[lxxix] Classroom Seat Time Saved. Available at: https://tools.sbh4all.org/s/test-measures-toolkit/classroom-seat-time-saved/.
[lxxx] California School-Based Health Alliance. Key Performance Measures for School-Based Health Centers. Available at: http://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2014/10/CSHA-Key-Performance-Measures-for-SBHCs.pdf.
[lxxxi] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxxii] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxxiii] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxxiv] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[lxxxv] CMS Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf.